February 27, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0627-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Occupational Medicine. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 34-year-old female with a history of back pain. Her date of injury was ___. She has had left hip and leg pain as well. She was carrying a sheet of glass for a customer in a lumber yard in ___ when she strained her back. She then began with a numbness to the left foot, left leg weakness, back pain, and left hip pain. She tried therapy, which did not help. She also tried medications which did not help. An MRI scan showed a bulging disc at the L4/5 and L5/S1 levels. She had been off work since her injury. She did have an EMG of the lower extremities on 4/2/02 with the result being normal. On 5/14/02, 52102 and 5/28/02 she had an epidural steroid injectin and lumbar tendon sheath injections for myofascial syndrome. ___ then recommended the purchase of the EZ Brace.

REQUESTED SERVICE

The purchase of a LSO Back Brace is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Review of the medical records provided indicate that ___ MRI scan showed bulging discs at the L4/5 and L5/S1 levels. The EMG studies of the lower extremities were normal. She was treated appropriately with epidural steroid injections and injections for myofascial syndrome. She was also treated with medications and physical therapy. The report by ___ on 9/26/02 showed that straight leg raising did not produce radicular pain on either side. Motor testing showed no definite weakness in the lower extremities. There was a question of some minimal weakness in the left extensor hellicus longus; however, on repetitive testing of the muscle, it appeared to be normal. Sensation was intact. Reflexes were normal. The report from the ___ at ___ dated 8/23/02 showed that range of motion of the lumbar spine was 75% in flexion, 75% in extension, and 100% on right side bending, and 75% on left side bending.

Since ___ date of injury was ___, almost 14 months ago, because the examination by ___ was essentially normal, and because the proposed LSO back brace will immobilize the lumbar spine, there is no documentation of medical necessity for the proposed purchase of this item. At this time, ___ should be on a range of motion exercise program for the lumbar spine and should increase her activity. The LSO back brace will do the opposite, immobilizing the back.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief

Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 27th day of February 2003.